OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ADONNA FROMETA	**03/25/68**	**058-68-6478**
Patient Address: **666 E 233 STREET, APT.#1A, BRONX, NY 10466**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
CABRINI MEDICAL CENTER, 227 E 19th ST., NEW YORK, NY 10003

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

☒ Medical Record from (insert date) 2/14/07 to (insert date) PRESENT

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **LITIGATION**	**UPON CONCLUSION OF THIS LITIGATION**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Adonna Frometa — Date: 9/7/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

SLAWOMIR W. PLATTA
NOTARY PUBLIC-STATE OF NEW YORK
No. 02PL6171290
Qualified in Kings County
My Commission Expires July 23, 2011

OCA Official Form No.: 960

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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
ANDREW DAVY, MD, 1513 VOORHIES AVE, BROOKLYN, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

☒ Medical Record from (insert date) 2/14/07 to (insert date) PRESENT

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **LITIGATION**	**UPON CONCLUSION OF THIS LITIGATION**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Adonna Frometa

Signature of patient or representative authorized by law.

Date: 9/7/07

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SLAWOMIR W. PLATTA
NOTARY PUBLIC-STATE OF NEW YORK
No. 02PL6171290
Qualified In Kings County
My Commission Expires July 23, 2011

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Patient Address		
666 E 233 STREET, APT.#1A, BRONX, NY 10466		

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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
STANDUP M2I OF MANHATTAN, 253 E 77th ST, NEW YORK, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

☑ Medical Record from (insert date) 2/14/07 to (insert date) PRESENT

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: DIAGNOSTIC FILMS FROM 2/14/07 - PRESENT

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

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(Attorney/Firm Name or Governmental Agency Name)

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Adonna Frometa

Signature of patient or representative authorized by law.

Date: 9/7/07

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SLAWOMIR W. PLATTA
NOTARY PUBLIC-STATE OF NEW YORK
No. 02PL6171290
Qualified in Kings County
My Commission Expires July 23, 2010

OCA Official Form No.: 960

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Patient Address		
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7. Name and address of health provider or entity to release this information:
MIDTOWN MEDICAL PRACTICE, PC, 48 E 43rd ST, NEW YORK, NY 10017

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

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☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

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(b) ☐ By initialing here _____ I authorize _____

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7. Name and address of health provider or entity to release this information:
RAMESH BABU, MD, 530 FIRST AVE, SUITE 7W, NEW YORK, NY 10016

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

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- ☐ Other: _____

Include: (*Indicate by Initialing*)

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(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

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Adonna Frometa

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7. Name and address of health provider or entity to release this information:
WESTCHESTER MEDICAL CARE PC, 32-62 WESTCHESTER AVE, BRONX, NY 10461

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

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Adonna Frometa

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7. Name and address of health provider or entity to release this information:
GEICO, 750 WOODBURY RD., WOODBURY, NY 11797

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

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- ☒ Other: No-Fault file # 02930577201010127

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
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[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ADONNA FROMETA	**03/25/68**	**058-68-6478**
Patient Address: **666 E 233 STREET, APT.#1A, BRONX, NY 10466**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
MYRTLE PHARMACY, INC., 446-A MYRTLE AVE., BROOKLYN, NY 11205

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

9(a). Specific information to be released:

☒ Medical Record from (insert date) 2/14/07 to (insert date) PRESENT

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **LITIGATION**	**UPON CONCLUSION OF THIS LITIGATION**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Adonna Frometa

Signature of patient or representative authorized by law.

Date: 9/7/07

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

SLAWOMIR W. PLATIA
NOTARY PUBLIC-STATE OF NEW YORK
No. 02PL6171290
Qualified in Kings County
My Commission Expires July 23, 2011

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

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ADONNA FROMETA	**03/25/68**	**058-68-6478**
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
RANGA KRISHNA, M.D., 3262 WESTCHESTER AVE., BRONX, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

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_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

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All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Adonna Frometa — Date: 9/7/07

Signature of patient or representative authorized by law.

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7. Name and address of health provider or entity to release this information:
ARDEN RAISMAN, MD, 51 E 25TH ST, NEW YORK, NY 10010

8. Name and address of person(s) or category of person to whom this information will be sent:
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP

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